



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL EDGE HEALTHCARE GROUP
PO BOX 650268
DALLAS TX 75265

Respondent Name

NETHERLANDS INSURANCE CO

Carrier's Austin Representative

Box Number 01

MFDR Tracking Number

M4-11-1651-01

MFDR Date Received

December 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The workers comp carrier One Call Medical, never sent us a payment, not a denial."

Amount in Dispute: \$159.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC60 request. A copy of the DWC060 request was placed in the insurance carrier representative box 19, assigned to Flahive, Ogden & Latson on February 15, 2011. FOL File room Gordon Clayton stamped received the DWC060 request on February 16, 2011. A decision will therefore be issued based on the documentation available in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2010	73718	\$159.64	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The requestor did not submit copies of EOBs with the DWC060 request.

Issues

1. Did the requestor submit the DWC060 request pursuant to 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. Former 28 Texas Administrative Code §133.307(c)(2)(A), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of all medical bill(s) . . . as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration.” Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).

Former 28 Texas Administrative Code §133.307(c)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB.” Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).

Former 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of all applicable medical records specific to the dates of service in dispute.” Review of the submitted documentation finds that the requestor has not provided copies of medical records specific to the dates of service in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).

Former 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement including “a description of the health care for which payment is in dispute.” Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).

Former 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issues including “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues.” Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).

Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issues including “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).

The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307.

2. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor.

The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	November 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.